

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010886	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/08/2016
NAME OF PROVIDER OR SUPPLIER ELMCROFT OF MUNCIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 N MORRISON RD MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: 9/8/16</p> <p>Facility Number: 010886 Provider Number: 010886 AIM Number: N/A</p> <p>Residential Census: 82</p> <p>Sample: 7</p> <p>Elmcroft of Muncie was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure survey.</p> <p>QR was completed by 99993 on 09/09/16.</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE